

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-025468

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1698

JUN 20 1962

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY MADISON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS, MO.		c. CITY OR TOWN BETHALTO	
Length of stay in 1b 30 DAYS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF DECEASED (If NOT in hospital, give location) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS (If outside, give location) 527 S. PRAIRIE STREET	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First FLORIAN Middle A. Last FREY			4. DATE OF DEATH Month JUNE Day 6 Year 1962		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-14-1892	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) AUSTRIA, HUNGARY	
12. CITIZEN OF WHAT COUNTRY USA					

13a. FATHER'S NAME FLORIAN L. FREY		13b. MOTHER'S MAIDEN NAME THERESA PLATZ		14. NAME OF HUSBAND OR WIFE HELEN S. FREY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-I		16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Helen S. Frey, 527 S. Prairie St., Bethalto, Ill.	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO-PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 3 Wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) PULMONARY EDEMA		3 Wks
DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE		20 Yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CARDIAC & CEREBRAL DAMAGE - X-RAY EVIDENCE - LUNG TUMOR		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour VA a.m. 5-7-62 Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) VA	20f. CITY, TOWN, OR LOCATION JEFF. BRKS. MO.		

21. I attended the deceased from 5-7-62 to 6-6-62 and XXXXXX	
Death occurred at 3:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE Sam T. Nichols (Degree or title) SAM T. NICHOLS, M.D.		22b. ADDRESS VA HOSP. JEFF. BRKS. MO.		22c. DATE SIGNED 6-6-62	
23a. BURIAL CEMETERY OR CREMATORY HOLY CROSS		23b. DATE 6-6-62		23c. LOCATION (City, town, or county) (State) Gallispie, Ill. - ILL.	

24. FUNERAL DIRECTOR J.W. Wiese, Gallispie, Ill.		25. DATE RECD. BY LOCAL REG. 6-7-62		26. REGISTRAR'S SIGNATURE John Murphy	
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.